VERMONT

State of Vermont
Department of Health
Children with Special Health Needs
108 Cherry Street -- PO Box 70
Burlington, VT 05402-0070
HealthVermont.gov

[phone] 802-863-7338
[Toll free] 800-660-4427
[tty] 802-865-1325
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Agency of Human Services

Referral for Children with Special Health Needs
NUTRITION SERVICES

Instructions: When a nutritional assessment is required, please complete this form and return to the CSHN Nutrition Program, by email to AHS.VDHCSHNNutrition@vermont.gov, fax or mail to the above address.

Eligibility will be determined based on the child's nutritional needs and/or enrollment in Children's Integrated Services—Early Intervention. If the child is eligible, a CSHN community-based nutritionist will be assigned to the family. The nutritionist will set up an evaluation and any follow-up visits directly with the family.

If you have questions, please feel free to call CSHN at 800-660-4427, the Nutrition Program at 802-865-7709, or email at AHS.VDHCSHNNutrition@vermont.gov

Today's Date ____ /____ /____

Referral Source

Your name _____

Phone (____) _____ - _____ Email _____

Title _____

Address _____

City _____ Zip _____

☐ CSHN ☐ Primary Care ☐ Specialist ☐ Psychiatry ☐ Parent/Guardian ☐ CIS ☐ EEE
☐ School ☐ Childcare/Daycare ☐ PT ☐ OT ☐ VNA ☐ NICU ☐ WIC

Child and Family Information

Child's Name _____

Child's DOB _____ /_____ /_____ **Child's SSN** _____ - _____ - _____

Child's Sex ☐ Male ☐ Female

Parents/Guardian _____

Address _____

City _____ Zip _____

Phone (____) _____ - _____

Is the parent/guardian aware that this referral has been made? ☐ Yes ☐ No

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Medical/Health Information

Child's diagnosis or condition _____

Reason for nutrition referral _____

_____

Height _____ Weight _____ Date obtained _____ /_____ /_____

Program Participation Information

Children with Special Health Needs	☐ Yes ☐ No ☐ Don't know
Child Development Clinic	☐ Yes ☐ No ☐ Don't know
Children's Integrated Service – Early Intervention	☐ Yes ☐ No ☐ Don't know
Is nutrition included in the IFSP?	☐ Yes ☐ No ☐ Don't know
WIC Program	☐ Yes ☐ No ☐ Don't know
3SquaresVT (Food Stamps)	☐ Yes ☐ No ☐ Don't know

Insurance Information

Medicaid ☐ Yes ☐ No

Private Insurance ☐ Yes ☐ No

If yes, name of private insurer _____

ID# _____ Group# _____

Providers of Care

Child's Primary Care Provider _____

Address _____

City _____ Zip _____

Other Specialists (MD's, Feeding teams, etc.)

Name	Affiliation
_____	_____
_____	_____
_____	_____

Has the child ever seen a dietitian/nutritionist? ☐ Yes ☐ No

If yes, Name _____

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Medical/Nutritional Criteria

Please complete the following to identify program enrollment participation and nutritional risk criteria.

Growth Measurements

- ☐ Weight for length/height ratio less than 5%
- ☐ Weight for length/height ratio or BMI greater than the 85%
- ☐ Weight/length for age less than the 5%
- ☐ Flat growth curve (i.e. No weight or length gain in 3-6 months)

Medical Conditions that Place the Child at Nutritional Risk

- ☐ Congenital Cardiac Conditions
- ☐ Craniofacial Disorders (such as cleft lip/palate, etc.)
- ☐ Genetic Disorders (Syndromes such as Down, etc.)
- ☐ Developmental Disorders
- ☐ Endocrine Diseases
- ☐ Metabolic Disorders (such as PKU)
- ☐ Neuromuscular Disorders (such as CP, etc.)
- ☐ Seizure Disorders (Epilepsy)
- ☐ Other _____

_____

Feeding Problems
Of longer than 3 months duration

- ☐ Not age appropriate foods in child's diet
- ☐ Chewing/swallowing foods/liquids
- ☐ Gagging/choking on foods/liquids
- ☐ Mealtime Behaviors
- ☐ Delays in self feeding skills

Nutritional Related Problems/Concerns
Of greater than 3 months duration

- ☐ Constipation
- ☐ Diarrhea
- ☐ Vomiting/Reflux (GER)
- ☐ Nausea, Loss of Appetite
- ☐ Possible Food Drug interactions
- ☐ Food Allergies/Intolerances
- ☐ Feeding Tube/other special feeding equipment

Dietary Consumption Concerns
Of greater than 3 months duration

- ☐ Use of a special nutritional formula
- ☐ Poor diet quality (omission of many foods in food groups due to sensory/oral motor feeding issues)
- ☐ Infant is consuming < 16 oz of formula/day
- ☐ Consumption of < 3 meals/day
- ☐ Long term food refusal of many foods

Family Concerns

- ☐ Parents/Guardians have concerns about child's diet
- ☐ Family needs assistance with special formula
- ☐ Family requests information on other available food programs
- ☐ Family requests more information on general nutrition topic(s)

For office use:

☐ Feeding difficulties	☐ Underweight
☐ Diet inadequacy	☐ Overweight
☐ Constipation	☐ Food intolerance
☐ Drug/diet interactions	☐ Tube feeding
☐ Slow growth	☐ Other

Date of review ____ /____ /____

☐ CIS-EI only

Approved for services ☐ Yes ☐ No

Program Coordinator signature _____

If yes, Community Nutritionist assigned _____

If no, reason why _____

_____